1. Last Name **First Name** **MI**

NC Department of Health and Human Services
Public Health Nursing & Professional Development

PERSONAL DATA SHEET

2. Patient Number										--	H
3. Date of Birth						Month		Day		Year		

4. Race ☐ **1. White** ☐ **2. Black/African American**
☐ **3. American Indian/Alaska native** ☐ **4. Asian**
☐ **5. Native Hawaiian/Other Pacific Islander** ☐ **6. Other**
Ethnicity: Hispanic/Latino Origin? ☐ **Yes** ☐ **No**

5. Gender ☐ **1. Male** ☐ **2. Female**

6. County of Residence

Maiden & Other Names_____

_____

Physician/Primary Care Provider_____

Notice of Privacy Practices given by_____ date_____

Social Security No. _____

Medicaid No. _____

Medicare No. _____

Health Insurance Coverage _____

_____

_____

Self Pay % _____

_____

Name Used by Third Party Payor _____

Date	Mail Y/No	Address	Grade	Mar. Stat.	Contact Phone Number	Work/School Name/Phone	Wk/School Hrs
		Present Address					
		Address Change					
		Address Change					
		Address Change					
		Address Change					
		Directions					

English Speaking ☐ Yes ☐ No Language:_____
Migrant Farm Worker ☐ Yes ☐ No Refugee ☐ Yes ☐ No
Seasonal Farn Worker ☐ Yes ☐ No Homeless ☐ Yes ☐ No

Interpreter needed ☐ Yes ☐ No
COUNTRY OF ORIGIN: _____

Confidential Contact _____ Phone _____
Name Relationship Address

Emergency Contact_ _____ Phone _____
Name Relationship Address

Persons living in home	DOB or Age	Gender	Relationship to patient, school and grade, away, deceased (date)

DHHS 2800 (Revised 12/04)
PHNPD (Review 12/07)

Patient Name, #, or DOB
or
Attach Patient Label Here

SOURCES OF INCOME

Date	Name of Family Members with an Income	List all Employers or Sources of Income	Dates of Employment From To	Wages	AFDC SSI	Retirement	Other	Total Income Before Taxes

THE ABOVE INFORMATION I HAVE GIVEN IS CORRECT. I UNDERSTAND THE HEALTH DEPARTMENT HAS THE RIGHT TO CHECK THIS INFORMATION.

Interviewer's signature		**Patient's signature**		**Family Size**	**Total Income Before Taxes**
(Signature)	*(Date)*	*(Signature)*	*(Date)*		
(Signature)	*(Date)*	*(Signature)*	*(Date)*		
(Signature)	*(Date)*	*(Signature)*	*(Date)*		
(Signature)	*(Date)*	*(Signature)*	*(Date)*		
(Signature)	*(Date)*	*(Signature)*	*(Date)*		
(Signature)	*(Date)*	*(Signature)*	*(Date)*		

ENVIRONMENT

Date	Food Stamps	Free Lunch Prog.	WIC	Working Refrig.	Working Stove	Power On	Heat	Water System Public	Water System Other	Indoor Plumb.	Review Dates	Review Dates

PERSONAL DATA (DHHS 2800)

NAME, NUMBER, ETC.	Attach in this space the computer generated identification label or emboss the information imprinted on the patient's plastic identification card. If a label or a plastic card is not available, record by hand the patient's name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YYYY), race, ethnicity, gender, and county of residence.
MAIDEN AND OTHER NAMES	Record maiden and/or other names, such as previous married names, that would help to identify the patient. Include all possibilities by which this individual may be identified in this and/or other agency files, doctors' offices, telephone directory, etc.
PHYSICIAN/PRIMARY CARE PROVIDER	Record name of patient's physician/primary care provider or any other care provider that can be identified.
NOTICE OF PRIVACY PRACTICE	Record signature of person giving Notice of Privacy Practice and date given.
SOCIAL SECURITY NUMBER	Record patient's social security number.
MEDICAID NUMBER	Record patient's Medicaid number if applicable.
MEDICARE NUMBER	Record patient's Medicare number if applicable.
HEALTH INSURANCE COVERAGE	Record name of the patient's private carrier.
SELF PAY%	Record % of pay for the patient.
NAME USED BY THIRD PARTY PAYOR	Record name used by Medicaid, insurance, etc. where the name or spelling of the name is different than the Department's records.
DATE	Enter date the initial information is recorded. In most cases this will coincide with the date a staff member first sees the person.
MAIL Y/NO	Indicate by "Y" for yes or "NO" for no whether or not the patient wants mail delivered to their address. When no is indicated, record in the space "**Confidential Contact**" the address where mail should be sent.
PRESENT ADDRESS	Record the location of the current residence. Include mail addresses when different.
GRADE	Record the number of the last school grade completed when the patient is an adult. Record the grade the patient is enrolled in when the patient is a school-age child.
MARITAL STATUS	Record here the word, which best describes the patient's present status. Single = never married; married = currently married; sep. = not legally divorced; div. = legally divorced; wid. = spouse legally dead.

PERSONAL DATA (DHHS 2800 cont)

CONTACT PHONE NUMBER	Record the phone number or numbers where the patient can be reached; home (present address and/or permanent address) and/or mobile phone number.
WORK/SCHOOL PHONE/NAME	Record telephone number where the patient is employed or attends school along with the name of work/school.
WORK/SCHOOL HOURS	Record here the hours the patient is employed or attends school.
ADDRESS CHANGE	Enter the date of the address change. Enter the full address change. Line through an outdated address, but do not erase or obliterate. Old addresses can be useful identifiers. Record new/martial status and phone numbers as they change.
DIRECTIONS	Record full driving directions to present address.
PERMANENT ADDRESS	Record permanent address when different from the present address (e.g. student away from home). Use ditto marks if same as above.
ENGLISH SPEAKING/ MIGRANT	Check "yes" or "no" for each item. Check Refugee only if entered U.S. within the past 8 months. Write in "language" if not English speaking, and note "Country of Origin" if applicable.
CONFIDENTIAL CONTACT	Record name, relationship, address and phone number of the person who may be contacted when the patient does not want Health Department to contact them at home. When the "mail" column above is marked with a "No" an address must be recorded here.
EMERGENCY CONTACT	Record here the name, address, relationship and phone number of the next of kin or person closest to the patient who can make vital decisions in the event of an emergency.
PERSONS LIVING IN HOME	List all household members by name, from oldest to youngest. Start with spouse or parent then children, brothers and sisters, <u>unrelated</u> household members, etc. Record other important circumstances in the space to the right.
DOB OR AGE	Acquire precise data for siblings when possible. Approximate data may be adequate for relatives.
GENDER	Record the gender even when apparent from first name.
RELATIONSHIP TO PATIENT, SCHOOL AND GRADE, AWAY, DECEASED (DATE)	Note the significance of this person to patient.

PERSONAL DATA- BACK SIDE (DHHS 2800)

SOURCES OF INCOME

PATIENT'S NAME AND NUMBER OR DOB	Enter the patient's name and number or date of birth.
DATE	Enter here the date the information is obtained/recorded.
PERSONS WITH INCOME	List all persons whose income helps to support this patient.
LIST ALL EMPLOYERS OR SOURCES OF INCOME	List names of the employers for the patient and others whose income helps to support the patient. List sources such as social security, disability, etc.
DATES OF EMPLOYMENT	Record the period of employment (e.g., 6/02 to present) for each person listed.
WAGES	Record dollar figure received by each person listed.
AFDC/SSI	Record amount of assistance patient receives and indicate source.
RETIREMENT	Record dollar amount patient receives from Social Security or any other pensions.
OTHER	Record dollar amount patient receives, as support from any source not covered in the previous columns.
TOTAL INCOME BEFORE TAXES	Add across the page to total the amount of individual's income. This figure should be transferred to the Total Income before Taxes item in next section.
INCOME STATEMENT RIGHT TO CHECK	Use this section to verify financial status when financial eligibility has a bearing on service eligibility.
INTERVIEWER'S SIGNATURE	Enter the signature of the person attesting to the patient's signature.
DATE	Record the date the interviewer signs.
PATIENT'S SIGNATURE AND DATE	Have the patient sign and date, affirming the validity for the income information.
FAMILY SIZE	Record the number of individuals supported by the Total Income Before Taxes.
TOTAL INCOME BEFORE TAXES	Record total amount of income that helps to support the family.

PERSONAL DATA- BACK SIDE (DHHS 2800 cont)

ENVIRONMENT

DATE	Record date the information is documented.
FOOD STAMPS	Record "Y" if patient receives food stamps, "N" if not.
FREE LUNCH PROGRAM	Indicate "Y" or "N" whether the patient or patient's children are eligible for school free lunch program.
WIC	Indicate "Y" or "N" whether the patient receives WIC supplements.
WORKING REFRIGERATOR STOVE	Indicate "Y" or "N" whether the appliances are operable.
POWER ON	Record by "Y" or "N" whether the power is currently on, not whether the residence is wired for power.
HEAT	Record the heat source in the patient's residence.
WATER SYSTEM PUBLIC/OTHER	Indicate whether patient's residence is on a municipal system or describe other type by placing a "Y" in the appropriate box.
INDOOR PLUMBING	Indicate by "Y" or "N" whether the patient has operable indoor facilities.
REVIEW DATES	These areas may be used to indicate that the preceding information has been reviewed at a subsequent interview with the patient and the information remains the same. When the situation changes, use the date column to the far left and another line to record changes in the patient's environment.